CONFIDENTIAL

State of Iowa

AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, submit this Affidavit of Termination
(Print Name of Employee)

of Domestic Partnership to cancel the Affidavit of Domestic Partnership previously submitted.

The Domestic Partnership between I and _____, ended on:
(Print Name of Domestic Partner)

_____.
(Date of Termination)

OR

My Domestic Partner, _____, died on: _____.
(Print Name of Domestic Partner) (Date of Death)

I understand that I have already agreed in the Affidavit of Domestic Partnership previously submitted, that after termination of the Domestic Partnership, another Affidavit of Domestic Partnership cannot be filed with my personnel assistant until twelve months have elapsed, after which I may enroll a new Domestic Partner in my health and dental care programs subject to the State's eligibility and enrollment rules.

I further understand that this Affidavit of Termination of Domestic Partnership initiates no change to my actual insurance coverage. If the domestic partner relationship is terminated, coverage for the domestic partner will terminate at the end of the month in which my personnel assistant receives the necessary signed insurance application/change forms. The termination affidavit and the insurance applications must be signed within 30 days of each other.

_____
(Signature of Employee)

_____
(Employee's Social Security Number)

_____
(Date)

_____
(Signature of Personnel Assistant)

_____
(Date Received from Employee)